STATE OF MICHIGAN

DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

Before the Director of the Department of Insurance and Financial Services

In the matter of:

Prescribed Therapy
Petitioner **File No. 21-1738**

v

Wolverine Mutual Insurance Company
Respondent

Issued and entered
this 19th day of January 2022
by Sarah Wohlford
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On November 16, 2021, Prescribed Therapy (Petitioner) filed with the Department of Insurance and Financial Services (Department) a request for an appeal pursuant to Section 3157a of the Insurance Code of 1956 (Code), 1956 PA 218, MCL 500.3157a. The request for an appeal concerns the determination of Wolverine Mutual Insurance Company (Respondent) that the cost of treatment, products, services, or accommodations that the Petitioner rendered was inappropriate under Chapter 31 of the Code, MCL 500.3101 to MCL 500.3179.

The Petitioner's appeal is based on the denial of a bill pursuant to R 500.64(3), which allows a provider to appeal to the Department from the denial of a provider's bill. The Respondent issued the Petitioner a bill denial on August 20, 2021. The Petitioner now seeks reimbursement in the full amount it billed for the dates of service at issue.

The Department accepted the request for an appeal on November 23, 2021. Pursuant to R 500.65, the Department notified the Respondent and the injured person of the Petitioner's request for an appeal on November 23, 2021 and provided the Respondent with a copy of the Petitioner's submitted documents. The Respondent filed a reply to the Petitioner's appeal on December 14, 2021.

II. FACTUAL BACKGROUND

This appeal concerns the appropriate reimbursement amount for home health services on July 2, 3, 4, 5, 6, and 7, 2021 under Healthcare Common Procedure Coding System (HCPCS) Level II code G0156, which is described as home health aide, in a home or hospice setting, each 15 minutes.

With its appeal request, the Petitioner submitted documentation that included the Respondent's determination, its 2019 charge description master, excerpts from the Federal Register regarding the Home Health Provider Prospective Payment System (HHPPS), and a narrative of its reason for the appeal.

The Petitioner's request for an appeal stated:

> This is not a Medicare case, the [injured person's] Medicare is not being billed, the [Respondent] is not a Medicare intermediary, does not pay like Medicare, and there is nothing in the no fault law that says no fault care is bound by Medicare care guidelines. Other discussions revolved around [the Respondent's] opinion that the MCCA sets the payment rate, when the law is very clear to the contrary. When utilizing Medicare reimbursable codes (as we do) reimbursement is 200% of Medicare, or the providers CDM rate (which we provided). We also provided the CY 2021 Federal Register Home Health Payment Rates. The denial code on the EOB states" Note 40: Service is approved or denied pursuant to the account's direction." This denial code is meaningless, as it does not give the provider any information, reason, etc. as to the reason of the underpayment or denial. Furthermore, there is no section in the no fault law that allows subjective determination of payment rate, by the MCCA or any other entity. Payment is via Medicare fee schedule.

In its reply, the Respondent stated that Medicare does not provide an amount payable for 24-hour attendant care provided in a person's home. Specifically, the Respondent stated:

> [The Petitioner] began providing attendant care to the [injured person] on July 2, 2021. Prior to providing services, it sent [us] a Charge Description Master ("CDM") that stated it was implemented in January 2013 and that quoted a charge of $[redacted]/hour for home health aide care. [T]he Petitioner then provided home health aide care to the [injured person] and billed [us] $[redacted]/hour, for a total of $[redacted] for 6 days. [O]ur medical bill review company repriced the bill, allowing a charge of $[redacted] per hour "priced per charge master." On August 19, 2021, [we] reconsidered the charges, allowing $[redacted] per hour "pursuant to the account's direction."

On November 23, 2021, the Department requested that the Petitioner submits its CDM. See MCL 500.3157(7). The Petitioner responded and submitted its CDM to the Department on November 24, 2021.

III. ANALYSIS

Director's Review

Under MCL 500.3157a(5), a provider may appeal an insurer's determination that the provider overutilized or otherwise rendered inappropriate treatment, products, services, or accommodations, or that

the cost of the treatment, products, services, or accommodations was inappropriate under Chapter 31 of the Code. This appeal involves a dispute regarding cost.

For dates of service after July 1, 2021, MCL 500.3157 governs the appropriate cost of treatment and training. Under that section, a provider may charge a reasonable amount, which must not exceed the amount the provider customarily charges for like treatment or training in cases that do not involve insurance. Further, a provider is not eligible for payment or reimbursement for more than specified amounts. For treatment or training that has an amount payable to the person under Medicare, the specified amount is based on the amount payable to the person under Medicare. If Medicare does not provide an amount payable for a treatment or rehabilitative occupational training under MCL 500.3157(2) through (6), the provider is not eligible for payment or reimbursement of more than a specified percentage of the provider's charge description master in effect on January 1, 2019 or, if the provider did not have a charge description master on that date, an applicable percentage of the average amount the provider charged for the treatment on January 1, 2019. Reimbursement amounts under MCL 500.3157(2), (3), (5), or (6) may not exceed the average amount charged by the provider for the treatment or training on January 1, 2019. See MCL 500.3157(8); MAC R 500.203.

MCL 500.3157(15)(f) defines "Medicare" as "fee for service payments under part A, B, or D of the federal Medicare program established under subchapter XVIII of the social security act, 42 USC 1395 to 1395lll, without regard to the limitations unrelated to the rates in the fee schedule such as limitation or supplemental payments related to utilization, readmissions, recaptures, bad debt adjustments, or sequestration." Under MAC R 500.203, reimbursements payable to providers are calculated according to "amounts payable to participating providers under the applicable fee schedule." "Fee schedule" is defined by MAC R 500.201(h) as "the Medicare fee schedule or prospective payment system in effect on March 1 of the service year in which the service is rendered and for the area in which the service was rendered." Accordingly, reimbursement to providers under MCL 500.3157 is calculated either on a fee schedule (i.e., fee-for-service) basis or on a prospective payment system basis.

HCPCS Level II Code G0156 has an amount payable under Medicare when it is billed on a prospective payment system basis. No payment amount is available for HCPCS Level II Code G0156 under on a fee-schedule basis because that code is not priced separately. Although the Petitioner stated that it was billing on the basis of the HHPPS, the Petitioner did not provide any supporting documentation to substantiate this assertion. Where there is no amount payable under Medicare, reimbursement is calculated based on a provider's charge description master or average amount charged on January 1, 2019. See MCL 500.3157(7).

To calculate the appropriate reimbursement amount, the Department relied on the Petitioner's submitted CDM as of January 1, 2019, for HCPCS Level II code G0156. Pursuant to MCL 500.3157(7), the amount payable to the Petitioner for the procedure code and dates of service at issue are as follows:

HCPCS code	January 1, 2019 CDM amount	55% of the January 1, 2019 CDM amount	4.11% CPI adjustment for	Amount payable for the dates of service at issue
G0156	$[redacted]	$[redacted]	$[redacted]	$[redacted]/unit[1]

Accordingly, the Department concludes that the Petitioner is due additional reimbursement for the dates of service at issue.

IV. ORDER

The Director reverses the Respondent's determination dated August 20, 2021 that the cost of the treatment rendered on the dates of service at issue in this appeal was inappropriate under Chapter 31 of the Code, MCL 500.3101 to MCL 500.3179.

The Petitioner is entitled to reimbursement in the amount payable under MCL 500.3157 for the treatment on the dates of service discussed herein, and to interest on any overdue payments as set forth in Section 3142 of the Code, MCL 500.3142. R 500.65(6). The Respondent shall, within 21 days of this order, submit proof that it has complied with this order.

This order applies only to the treatment and dates of service discussed herein and may not be relied upon by either party to determine the injured person's eligibility for future treatment or as a basis for action on other treatment or dates of service not addressed in this order.

This is a final decision of an administrative agency. A person aggrieved by this order may seek judicial review in a manner provided under Chapter 6 of the Administrative Procedures Act of 1969, 1969 PA 306, MCL 24.301 to 24.306. MCL 500.244(1); R 500.65(7). A copy of a petition for judicial review should be sent to the Department of Insurance and Financial Services, Office of Research, Rules, and Appeals, Post Office Box 30220, Lansing, MI 48909-7720.

Anita G. Fox
Director
For the Director:

X Sarah Wohlford

Sarah Wohlford
Special Deputy Director
Signed by: Sarah Wohlford

[1] To calculate the amount payable, the Department utilized the $[redacted] an hour charge stated on the Petitioner's 2019 charge description master for the HCPCS code G0156 and divided by 4 to obtain the amount payable per 15-minute unit.